

Oceania Care Company Limited - Elmswood Rest Home

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Oceania Care Company Limited

Premises audited: Elmswood Rest Home

Services audited: Dementia care

Dates of audit: Start date: 20 October 2020 End date: 21 October 2020

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 29

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Elmswood Rest Home is an Oceania Healthcare Limited facility that can provide care for up to 38 residents requiring dementia level of care. Occupancy on the first day of audit was 29.

This surveillance audit was conducted against the relevant Health and Disability Services Standards and the service contract with the district health board.

The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with family, management, staff, and a nurse practitioner.

The previous requirement for improvement at the certification audit relating to the development of corrective actions from resident incidents has been closed.

The previous requirement for improvement relating to residents' cultural needs being reflected in care planning remains open.

There are additional areas identified as requiring improvement at this audit relating to: complaints management; general practitioner three-monthly reviews; and restraint approval.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service is provided to residents and family on admission and is available within the facility.

Staff communicate with family members following any accident/incident and this is recorded in the residents' files.

Family and the nurse practitioner interviews confirmed that the environment is conducive to communication, including the opportunity to raise issues and that staff communication with residents is respectful.

There is a documented complaints policy. The business and care manager is responsible for managing complaints. Complaints are investigated in a timely manner with corrective actions implemented where required.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Oceania Healthcare Limited has a mission, vision and values, that are conveyed to all concerned. The organisation's national office has an electronic database to collect and collate facility submitted data for ongoing monitoring of service delivery.

The facility is managed by a qualified and experienced business and care manager, who is supported by a clinical manager responsible for the oversight of clinical service provision. The clinical manager is a registered nurse and holds a current practising certificate. The facility management team is supported by the regional clinical manager and the regional operations manager.

There is an Oceania Healthcare Limited quality and risk management system.

Quality and risk performance is monitored through the organisation's reporting systems. Corrective action plans arising from quality activity results are documented and implemented. There is a database to document risks and controls.

A system is in place to report, analyse, and respond to adverse, unplanned, or untoward events. Adverse event information is openly shared with the residents' family members.

Oceania Healthcare Limited human resource policies and procedures are implemented and follow legislated guidance. Practising certificates for staff and contractors who require them are current and validated annually. Newly recruited staff undertake orientation appropriate to their role. There is an implemented, ongoing annual training and education plan for all staff.

There is a documented rationale based on best practice for determining staffing levels and skill mix to provide safe service delivery. Staffing levels are adequate across the service, meet the requirements of the district health board contract.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Registered nurses assess residents on admission to the facility. The nurse practitioner completes a medical assessment on admission. The initial care plan guides care and service provision during the first three weeks after the residents' admission.

The interRAI assessment is used to identify residents' needs; these are completed within the required timeframes.

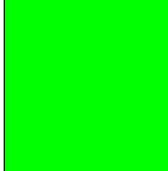
Person centred care plans are developed during the first three weeks after admission using information from the interRAI assessment using an electronic system and implemented within the required timeframes. Residents' needs, goals and outcomes are identified. All residents' files reviewed demonstrated evaluations were completed at least six-monthly. Residents and their relatives are involved in the care planning process and notified regarding any changes in resident's health status.

Short-term care plans are in place to manage short-term issues or problems as they arise. Handovers between shifts guide continuity of care. A management system is in place. Medication management is in line with the legislation and contractual requirements. Medications are administered by registered nurses and health care assistants who have completed current medication competency requirements.

The activity programme is managed by a diversional therapist. The programme provides residents with a variety of individual and group activities and maintains their links with the community. The service uses its facility van for outings in the community. Family can participate in the activities programme.

The food service meets the nutritional needs of the residents. The service has a current food control certificate. Kitchen staff have food safety qualifications.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is displayed in the facility.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator who is a registered nurse. On the day of the on-site audit no restraints or enablers were in use. Restraint is only used as a last resort when all other options have been explored.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection data is collated, analysed, trended and benchmarked. Monthly surveillance data is reported to staff and to the Oceania Healthcare National Office. There have been no outbreaks reported since the previous audit.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	1	3	0	0	0
Criteria	0	36	1	3	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>The policy available to staff is overdue for review. Complaints forms, and a post box to submit the complaint, are available near the entrance to the facility. The policy requires that all complaints be entered onto the complaints register.</p> <p>Family members are provided with information on the complaints process as part of the admission process. The BCM discusses the complaints process with family to ensure their understanding. Family interviews confirmed that they are aware of the complaints process.</p> <p>Meeting minutes evidenced that the complaints process is reiterated at two-monthly family meetings, and that during the meetings concerns are raised, discussed, and feedback provided on services.</p> <p>The observed complaints register recorded the verbal complaints received from family. However, this was not a controlled document.</p> <p>Staff and family interviews confirmed residents' awareness of opportunities and processes to raise any concerns and to provide feedback on services. Interviews with family members confirmed that issues and concerns raised had been dealt with promptly and to their satisfaction.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner (HDC) or other external authorities since the previous audit.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>PA Low</p>	<p>Family members interviewed confirmed that they are consulted on the individual preferences of the resident, including interests and religious observances, and that they are involved in the assessment and care planning processes. Residents participate in the discussion when able. Staff and family interviews evidenced that residents are provided with choices regarding their care and the services provided.</p> <p>However, the documented assessments and care plans did not consistently reflect the identification of cultural needs, spiritual values and beliefs of the residents. The previous corrective action relating to care plans reflecting cultural needs remains open.</p> <p>A spirituality and counselling policy ensures access for residents to a chosen spiritual advisor or counsellor where requested. There is an interdenominational religious service at the facility for residents who choose to attend.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The information packs provided to family prior to, or on admission of the resident to the facility, provide information on how the dementia service is delivered.</p> <p>An open disclosure policy sets out the process to guide staff and ensure that there is open disclosure of any adverse event where a resident has suffered unintended harm while receiving care. Completed accident/incident forms and residents' records reviewed demonstrated that family are informed if the resident has an accident/incident. Resident records and family interviews confirmed that they were also notified of a change in the resident's health. Family interviews confirmed that they are informed of any changes in resident status.</p> <p>Two-monthly family meetings inform family of facility events and activities and provide an opportunity to: give feedback; raise and discuss issues or concerns. Upcoming meetings are advertised on a notice board in the facility. Family and the business and care manager (BCM) interviews confirmed that upcoming meetings are advertised on the notice board in the facility and invites are sent via email. Minutes from the residents' meetings showed that a range of regular topics are discussed. Copies of meeting minutes are made available to family in the facility foyer for those who wish to take a copy. A two-monthly facility newsletter provides family with updates on facility events and activities.</p> <p>Family stated that they were able to discuss matters freely with staff and the BCM and that they were satisfied with the responses received.</p> <p>There is a policy that provides guidance and procedures for staff to ensure that residents who do speak English as their first language are offered interpreting services. Staff interviews confirmed that interpreter services would be accessed if required. At the time of audit there were no residents or family for whom</p>

		English was not their first language.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Elmswood Rest Home (Elmswood) is part of Oceania Healthcare Limited (Oceania).</p> <p>Oceania has a documented mission, vision and values statement, which reflect a person/family-centred approach to all residents. The mission, vision and values are displayed at the front entrance of the Elmswood facility. Interviews with staff and training records confirmed that these are communicated to staff during orientation and annual training. Elmswood has a documented facility specific budget, key performance indicators (KPIs) and business objectives, sighted on audit.</p> <p>The Oceania executive management team provides support to the facility, with communication occurring at least monthly. The facility provides the executive management team with ongoing electronic reporting of events and occupancy. A monthly progress report against identified KPI is generated by Oceania and sent to the facility (refer to 1.1.13). Reports sighted included key both clinical and business KPIs ranked against other Oceania facilities. These are discussed at monthly meetings with the regional operations manager.</p> <p>The BCM has been in this role for over two years, having previously worked as an administrator in the facility for two years. The BCM has completed Oceania management training and has a previous background in business management and human resources. The clinical manager (CM) supports the BCM and has been in the role for nearly 18 months, having previously practised as a registered nurse (RN) in the facility for 4 years. The CM holds a current RN practising certificate and is supported by the Oceania regional CM.</p> <p>Elmswood is certified to provide dementia level of care for up to 38 residents. There were 36 of the 38 rooms available with the 2 remaining rooms being used for storage. There were 29 beds occupied at the time of audit. All residents had been assessed as requiring dementia level care, including one resident under the age of 65 years.</p> <p>The facility holds contracts with the district health board (DHB) for the provision of dementia care, day care and respite care for up to 38 residents. At the time of the audit there were no residents accessing the respite or day care services.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system</p>	FA	<p>The Oceania documented quality and risk management framework is accessed by staff to guide service delivery.</p> <p>Policies are current, align with the Health and Disability Services Standards, and include references to good practice guidelines. Staff are made aware of policies at orientation as evidenced in staff interviews and orientation records. Oceania has a document control system to manage its policies and procedures. The Oceania management group reviews all policies with input from relevant personnel. New and revised policies</p>

<p>that reflects continuous quality improvement principles.</p>		<p>are introduced to staff at staff meetings and policy updates are included in relevant in-service education. This was confirmed in staff interviews. New and revised policies are available to staff in the nursing station. There was evidence that staff sign to confirm they have read each new policy and/or update.</p> <p>Service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators. These are collated in a monthly report. All aspects of quality improvement, risk management and clinical indicators are discussed at monthly staff meetings. Copies of meeting minutes are made available to staff and staff sign to confirm they have read these.</p> <p>There is documented evidence that the annual internal audit programme is implemented as scheduled (refer to 1.1.13.3). Reports reviewed show evidence that quality improvement data is being collected and collated with the identification of trends and analysis. Where required, corrective action plans from quality activities, including resident incidents, are developed, implemented, evaluated and closed out as evidenced in documentation reviewed. Staff interviews confirmed that they are advised of any subsequent changes to policies, procedures and practice and that they are kept informed of quality improvement activities through staff meetings and meeting minutes. The previous corrective action has been closed.</p> <p>Family stated they are notified of quality activities such as the satisfaction survey through the facility's family meetings.</p> <p>Family satisfaction surveys are completed twice yearly as part of the internal audit programme. Interview with the BCM and a review of survey results evidenced that areas for improvement such as laundry management are identified and actions implemented. Completed surveys sighted identified that respondents were satisfied with services provided.</p> <p>Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Accidents, incidents and corrective actions are discussed at staff meetings as evidenced in meeting minutes. Hazards are reviewed and discussed at each monthly health and safety meeting, as sighted in meeting minutes. Staff interviews confirmed an awareness of health and safety processes, and their responsibilities to report hazards, accidents and incidents promptly. There was evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed, and risks minimised. Current, annually updated Oceania and Elmswood specific hazard registers were available.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by</p>	<p>FA</p>	<p>The BCM confirmed in interview that they are aware of situations which require the facility to report and notify statutory authorities. These situations are reported to the appropriate authority via the Oceania head office. Since the last audit, there was evidence that the CMs appointment had been reported to the Ministry of Health under Section 31 of the Health and Disability Services (Safety) Act 2001.</p> <p>Staff training records reviewed confirmed that staff receive education on accident/incident reporting</p>

<p>the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>processes: at orientation and as part of the ongoing training programme. Staff interviews confirmed their understanding of the adverse event reporting process, and their obligation to document all untoward events. Reporting, management, and closure of adverse events is completed on an electronic system, as confirmed by the review of electronic records.</p> <p>Review of accident/incident reports evidenced assessments and observations completed post accidents/incidents when appropriate. The corrective actions arising from accidents/incidents documentation review were consistently implemented. The corrective action from the previous audit relating to the development and implementation of corrective actions relating to falls is closed.</p> <p>Accident/incidents data and trends are graphed, analysed, and benchmarked against other Oceania facilities. Staff interviews, and monthly staff meeting minutes, confirm that specific learnings and results from accidents/incidents are shared at monthly staff meetings and inform quality improvement processes.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions, as well as accountabilities, responsibilities and reporting lines.</p> <p>The sample of staff files reviewed demonstrated that recruitment processes include: reference checks; police vetting; identification verification; a position specific job description; drug screening, and a signed employment agreement.</p> <p>There are systems in place to ensure currency of annual practising certificates and practitioners' certificates. Current certificates were evidenced for all staff and contractors that required them.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. Interviews with health care assistants (HCA) confirmed that they are supported by experienced staff members until competent in personal care provision.</p> <p>The organisation has a documented mandatory annual education and training module/schedule specific to each role and relevant to the service and level of care provided. There are systems and processes in place to ensure that all staff complete their required mandatory training modules and competencies. Eleven care staff including HCAs, and activities staff have completed level four, or equivalent, dementia unit standards, as evidenced in documentation reviewed.</p> <p>The CM and two other RNs have completed interRAI assessment training and competencies. Education session attendance records evidenced that ongoing education is provided and is relevant to the service. Staff interviews and review of training records indicated that all staff, including RNs, undertake at least eight hours of relevant education and training per year.</p> <p>An annual performance appraisal schedule is in place and was implemented for staff who have been</p>

		employed for greater than one year, as evidence by staff files and training logs.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The organisation's staffing policy provides guidance to ensure staffing levels within the facility meet the residents' acuity needs and the minimum requirements of the DHB contract. Staffing levels are reviewed to accommodate anticipated workloads, identified numbers of residents, and skill mix needed. Staff are rostered on a rolling six-week duty roster.</p> <p>There are 25 staff employed in the facility, including the management team, clinical, activities and household staff. There are RNs and HCAs available to maintain provision of residents' care. Rosters sighted reflected staffing levels that meet current resident acuity and bed occupancy type. These evidenced that pool and part time staff are available for extra rostered duties utilised when additional staff were required to cover unplanned leave.</p> <p>The BCM and CM are on duty during the day, Monday to Friday. There is at least one RN rostered on each morning and afternoon seven days per week. There are four HCAs rostered in the morning and afternoon, and three HCAs at night.</p> <p>Interview with the BCM advised that both the CM and the BCM are on call after hours seven days a week and if required RN assistance can be sought from another Oceania facility located across the road.</p> <p>Observation of service delivery confirmed that resident needs are met in a timely manner. Family stated in interview that residents' needs are met by staff. Staff interviews confirmed that they have sufficient time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>A current medication management policy identifies all aspects of medicine management in line with current legislation and guidelines.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices in line with legislation, protocols and guidelines were observed. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities were consistently documented on the electronic medication chart.</p> <p>The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are no standing orders used at the facility.</p> <p>Medication fridge temperatures are monitored and are within the recommended range. Review of the medication fridge evidenced that the service does not store or hold vaccines and interviews with the RN</p>

		<p>confirmed this.</p> <p>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks and six-monthly stocktakes of medications are conducted in line with policy and legislation.</p> <p>The staff were observed administering medication and at interview demonstrated knowledge and clear understanding of their roles and responsibilities related to each stage of medication management as per policies and procedures. The RNs oversee the use of all pro re nata (PRN) medicines and documented effectiveness on the sighted electronic medication records. Current medication competencies were evident in staff files.</p> <p>At the time of the audit there were no residents who self-administered medicine at the facility.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food service policies and procedures are appropriate to the service. The seasonal menu has been reviewed by a dietitian. The food control plan is current (expires March 2021).</p> <p>Meals are prepared at another site owned by the organisation which is across the road from the facility. Meals are transported to the facility's satellite kitchen by van in hot boxes at mealtimes. Temperature monitoring of the food occurs prior to transportation, on delivery and prior to serving.</p> <p>The kitchen staff have relevant food hygiene and infection control training. The kitchen was observed to be clean and the cleaning schedules sighted.</p> <p>A nutritional assessment is undertaken for each resident on admission by the RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the production kitchen staff and updated when a resident's dietary needs change and when dietary profiles are reviewed six-monthly. Diets are modified as needed and the chef interviewed confirmed awareness of the dietary needs, likes and dislikes of residents at Elmswood. These are accommodated in daily meal planning. Special equipment to meet residents' nutritional needs is available.</p> <p>Resident satisfaction with meals was verified by family interviews. At lunchtime the meal service was observed and residents were seen to be given time to eat their meal and were not hurried. Those requiring assistance had this provided. There were staff on duty in each of the two dining rooms at meal times to ensure appropriate assistance was available to residents as needed.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The temperature of the fridge is monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated.</p>

		Staff have access to food items at any time of the day to satisfy residents nutritional desires or needs.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Long-term care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. Care planning includes specific interventions for long-term problems. Comprehensive behaviour assessments recorded triggers and de-escalation techniques. Individualised documented plans were in place to manage challenging behaviours to meet the specific needs of residents. Short-term care plans were in place for all short-term problems.</p> <p>The NP interviewed visits the facility twice a week. They verified that medical input is sought in a timely manner, medical orders are followed and care is of a high standard. Residents are reviewed three-monthly by the NP and more often if required (refer to 1.3.3.3).</p> <p>Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Wound care and continence products are available at the facility.</p> <p>Review of wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Where wounds required additional specialist input, this was initiated.</p> <p>Monthly observations such as weight and blood pressure were completed.</p> <p>The nursing progress notes were recorded and maintained. Family communication was recorded in the progress notes. In interviews, families confirmed that care and treatment met residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The residents' activities programme is implemented by a diversional therapist who is assisted by an activities' coordinator. Activities for the residents are provided 7 days a week, 9am to 5pm. The programme is run in two different areas of the facility with some activities being communal. A range of activities are made available for residents, staff and family to access when the activities staff are not on duty.</p> <p>The activities programme is displayed on the resident noticeboards. The activities programme provides variety in the content and incorporates: education; leisure; cultural; spiritual and community events. Van outings into the community are arranged once or twice a week.</p> <p>The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on the residents' interests, family and previous occupations is gathered during the interview with the resident and their family and documented. The residents' activity needs are reviewed six-monthly with the care plan and multidisciplinary review processes.</p> <p>Activities for the residents in this secure dementia service are organised to meet the abilities of the residents</p>

		<p>living at the facility. Activities are offered at times when residents are most physically active and/or restless. All files reviewed had an activities plan which addressed residents' 24-hour activity needs.</p> <p>In interviews, families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Person centred care plans are evaluated every six months in conjunction with the interRAI re-assessments or if there is a change in the resident's condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes.</p> <p>Families interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified in the resident's records and documented in the individual resident files reviewed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There is a current building warrant of fitness displayed at the entrance to the facility. There have been no alterations to the building since the previous audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Oceania surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. The CM is the infection control nurse (ICN) and is responsible for infection prevention and control in the facility. A signed position description, which includes requirements of the role and responsibilities, was sighted. The ICN has completed training for this role.</p> <p>Internal infection prevention and control audits are completed. Infection data is collated monthly by the CM and is submitted to Oceania national office. Monthly surveillance data is collated and analysed to identify any trends, possible aetiology and any required actions. This data is reported at the monthly staff, clinical and quality meetings.</p> <p>Interview with the ICN confirmed there had been no outbreaks since the previous audit.</p> <p>Covid-19 information is available to all visitors to the facility. Oceania information including Ministry of Health information was available on site. Infection prevention and control resources were available should a resident</p>

		infection or outbreak occur.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Negligible</p>	<p>Policies and procedures meet the requirements of restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The CM is the restraint coordinator and has undertaken training for this role.</p> <p>Restraint is minimised at this secure dementia service.</p> <p>The restraint coordinator provides support and oversight for enabler and restraint management and demonstrated a sound understanding of the organisation's policies, procedures, practice and their roles and responsibilities.</p> <p>On the day of audit interviews with staff and family members and documentation demonstrated that there were no residents using restraint or enablers.</p> <p>Interviews verify restraint is used as a last resort when all alternatives have been explored.</p> <p>Restraint and behavioural management is included in the staff orientation/induction processes. Ongoing education is identified on the staff education calendar sighted. Restraint competencies were evidenced in the staff files reviewed. However, patio bolts were observed on some residents' bedroom doors to prevent other residents entering the rooms. There was no documented evidence of approval or discussion with family relating to the use of these.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>The complaints policy that was available to staff is in line with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and includes the timeframes for responding to a complaint. However, this policy is overdue for review. A new policy was provided on the day of the audit; however, staff were not aware of the new policy and it could not be determined if this had formally superseded the expired policy.</p> <p>A complaints register is in place that included seven verbal complaints/concerns that had been raised by family over 2020. It includes: the date the complaint is received; the category of complaint and a summary of the complaint; the date of discussions with the parties involved; and the date the complaint is closed. However, the register is not on a controlled template. The BCM advised that there had been no written complaints received.</p> <p>The facility had audited the complaints process through interviews</p>	<p>i) The complaints policy available to staff is not current.</p> <p>ii) The complaints register in use was not a controlled document.</p> <p>iii) The internal audit of complaints did not follow the required criteria identified in the organisation</p>	<p>Ensure that:</p> <p>i) The complaints policy is current, reflects Right 10 of the Code and that all staff have read and understood the revised policy.</p> <p>ii) The complaints register in use is a controlled document.</p> <p>iii) The internal</p>

		with family members. However, this internal audit process did not review actual complaints and therefore meet the organisation requirements for collecting information on complaints that can be benchmarked against other facilities' and inform the quality management systems.	audit tool template.	audit of complaints follows the required criteria identified in the organisation audit tool template. 90 days
Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.	PA Low	The electronic process for assessing the cultural needs of residents requires the completion of a Māori health plan. However, for two residents who identified as Māori, cultural needs had not been identified, nor reflected in a plan of care.	Cultural needs for residents who identified as Māori were not consistently reflected in the assessment and care planning processes.	Ensure that cultural needs are assessed and addressed in the plan of care of all residents. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Residents are reviewed three-monthly by the NP and more often if required. However, there is no documented evidence in the five files reviewed, of the exception from monthly reviews when the resident's condition is assessed as stable, enabling three-monthly reviews.	The exception from monthly GP/NP reviews had not been documented in the five files reviewed.	Ensure exception from monthly GP/NP reviews is documented and signed by the GP/NP. 90 days
Criterion 2.1.1.4 The use of enablers shall be voluntary and the least	PA Negligible	Patio bolts were in place on the doors to some residents' rooms. The business and care manager stated that these had been installed on the request of the resident's EPOA/family for the purpose of preventing other residents entering the room. However, there was no	Patio bolts were in place on residents' bedroom doors	Ensure: i) External locks are not in use

<p>restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>		<p>documented evidence that the use of these patio bolts had been discussed with or approved of by EPOA/family. The facility has provided evidence that the locking devices have been removed from resident bedroom doors.</p>	<p>for the purpose of preventing other residents entering the room.</p>	<p>on resident bedrooms. ii) Alternative non-restrictive strategies are implemented to reduce the likelihood of residents entering another resident's room. 90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.